MENTALLY ILL OFFENDER CRIME REDUCTION GRANT PROGRAM

OVERVIEW OF STATEWIDE EVALUATION FINDINGS

MARCH 2005

THE MENTALLY ILL CRIME REDUCTION GRANT PROGRAM

Recognizing that jails have become the primary source of treatment for the mentally ill, the California State Sheriffs Association and Mental Health Association of California sponsored legislation to create the Mentally Ill Offender Crime Reduction Grant (MIOCRG) program – an unprecedented initiative designed to learn what works in reducing recidivism among mentally ill offenders (Chapter 501, Statutes of 1998). This legislation directed the Board of Corrections (BOC) to award and administer competitive grants supporting the implementation and evaluation of locally developed demonstration projects. Funds allocated to the MIOCRG program (over $80.5 million) supported 30 projects in 26 counties (Attachment 1). To identify what works most effectively in reducing recidivism among mentally ill offenders, the legislation required the BOC to conduct a statewide evaluation of the MIOCRG program.

Overview of Projects

The MIOCRG projects addressed a wide array of service needs identified by counties during the collaborative local planning process required by the enabling legislation. Although some of the projects emphasized enhanced in-custody services, such as counseling and discharge planning, the majority of projects involved a combination of in-custody and post-custody interventions. The enhanced community-based services offered by the projects included residential or outpatient mental health treatment; assistance in securing disability entitlements, housing, vocational training, and employment; individual and group counseling; life skills training; substance abuse education and counseling; medication education, management and support; crisis intervention; and advocacy. Some projects delivered these services directly to participants; other projects were designed to broker and/or link clients to existing public and/or private sector treatments, services and interventions. Treatments varied from short-term (two to six months in duration) to those that lasted a year or more.

In terms of program approaches, nearly two-thirds of the projects drew upon the Assertive Community Treatment (ACT) model. ACT consists of a multidisciplinary group of mental health professionals and social workers that service clients as a team rather than as individual providers – and, for the most part, in the community rather than in the hospital or offices. ACT utilizes low client-staff ratios to ensure sufficient one-on-one contact with clients and to individually tailor services to the needs of clients. ACT services are frequently available 24 hours a day, seven days a week, and are typically provided over an extended period of time. Several counties modified the ACT model by adding a probation officer or officers to the team, thereby combining intensive probation supervision with intensive case management. In addition, in some counties, the multidisciplinary team included a psychiatrist, nurse, substance abuse specialist, housing specialist, benefits specialist and/or occupational therapist.

Nine counties created a mental health court or calendar. Although there were different designs among these courts and several incorporated ACT model components for service delivery, the piloted mental health courts typically involved judges, defense attorneys, prosecutors, probation officers and mental health professionals collaborating in the belief that effective community-based treatment was an appropriate and viable option for some mentally ill offenders. The mental health courts often involved the use of case conferencing to discuss treatment options and progress, and monitored defendants through subsequent hearings (e.g., weekly or monthly court appearances, depending on the case and/or jurisdiction).

In more than half of the projects, participation was voluntary; clients agreed to participate and signed a consent form to that effect. In other projects, participants were ordered into the program by the court, generally as a condition of probation.

Populations Served

In designing and implementing their projects, counties had to make decisions about a wide range of eligibility issues, including what specific mental health diagnoses were appropriate given the program design, what levels and kinds of commitment offenses and/or criminal histories would fit, and what other criteria that would render candidates ineligible for project participation.

Mental Health Diagnoses: The primary diagnosis of over half of the individuals served by the projects was mood disorders. In addition to interfering with a person's ability to function, bipolar and other mood disorders typically involve recurrent thoughts of death or suicide. In addition, approximately one-fourth of the participants were clinically diagnosed as delusional and nearly 11 percent as schizophrenic. Thirteen counties targeted mentally ill offenders who also had substance abuse diagnoses (clinically described as co-occurring disorders).

Criminal Justice History: In order to ensure that their projects would serve mentally ill offenders without endangering public safety, most counties focused on particular subsets of offenders. Some counties required participants to have two or more previous arrests while others deemed one prior arrest sufficient for program participation. Several jurisdictions limited eligibility to offenders with misdemeanor charges while other counties allowed property, substance abuse and other non-violent felonies. Most of the counties opted to exclude offenders who were in jail at the time of program entry for a violent or serious felony, some counties excluded offenders with any history of violence, and other counties excluded offenders with any past felony arrests.

Exclusions: Eligibility exclusions in place in one or more counties included: not being a county resident; being on parole or under conservatorship; being a third strike candidate; having been found not guilty by reason of insanity or incompetent to stand trial, having an Immigration and Naturalization Service hold, felony warrant or any other hold; needing supervision by a sex offender program or gang unit; and having a primary diagnosis of a personality disorder.

Statewide Evaluation

In fulfilling its statutory mandate to evaluate the overall effectiveness of the MIOCRG program in reducing recidivism among mentally ill offenders, BOC staff developed a comprehensive research design that included analyses to:

1. Determine differences in criminal justice and quality of life outcomes between participants receiving the enhanced treatment offered by the MIOCRG projects (ET) and a comparable group receiving treatment as usual (TAU);

2. Examine the extent to which the magnitude of the treatment effect was related to subgroups of program participants; and

3. Assess the relationship between outcomes and the extent to which projects incorporated the attributes of Assertive Community Treatment.

These analyses involved a uniform set of variables called Common Data Elements (CDEs) that were developed in collaboration with local project managers and researchers. In addition to providing background information on participants (intake data), the CDE variables provided information about the nature and frequency of the services received by participants (intervention data) as well as their subsequent criminal conduct, psychological functioning, and conditions of general living (outcome data). Intervention and outcome data were captured in six-month intervals from program entry, and the projects submitted CDE files to the BOC on a semi-annual basis throughout the grant period.

The statewide evaluation had two advantages: 1) the aggregated data afforded the opportunity to reach conclusions that have statewide implications, and 2) the larger research sample increased the statistical power of the investigation, thereby increasing the chances of identifying overall program effects. Although the MIOCRG projects involved over 8.000 mentally ill offenders, the total statewide sample consisted of 4,741 individuals who participated in 20 local projects that satisfied the criteria for inclusion in the evaluation (i.e., true or quasi-experimental design, with an adequate comparison group).[1] Of this total, 2,472 individuals were in the ET group and 2,269 were in the TAU group. Except for significant differences on two intake variables (gender and homelessness) due to project design and data collection issues, the two groups were comparable, which is essential to the validity of the research findings. Attachment 2 outlines the background characteristics of the cases included in the final database.

The analysis of intervention data found that the individuals receiving the enhanced treatment offered by the MIOCRG projects, when compared to individuals receiving treatment as usual, were: 1) more comprehensively diagnosed and evaluated regarding their mental functioning and therapeutic needs; 2) more quickly and reliably provided with services designed to ameliorate the effects of mental illness; 3) provided with more complete after-jail systems of care designed to ensure adequate treatment and support; and 4) monitored more closely to ensure that additional illegal behavior, mental deterioration, and other areas of concern were quickly addressed. The hypothesis testing examined the effect of this enhanced treatment on 14 criminal justice and quality of life variables (Attachment 3). All results are for a program participation time of two years following the individuals' release from jail.

Criminal Justice Outcomes: To determine what works in reducing recidivism among mentally ill offenders, the statewide research examined the impact of the projects on eight criminal justice variables. The results (Table A) indicate that MIOCRG project participants were booked less often, convicted less often, and convicted of less serious offenses than individuals receiving TAU. In addition, fewer participants served time in jail and, when they did serve time, they were in jail for fewer days than were TAU participants.

In reviewing these findings, it is important to keep in mind that treatment as usual changed dramatically during the course of the MIOCRG Program, most notably with the advent of AB 2034 and Proposition 36, both of which provide treatment and support services to mentally ill offenders. However, even with the added treatment and support provided by these initiatives, the MIOCRG program's enhanced services had a greater effect on criminal justice outcomes.

[1] The data for certain projects were excluded from the statewide evaluation. Because the focus of the statewide evaluation was on identifying program effects (i.e., comparing outcomes for those in the ET with those in the TAU group), the four projects that lacked an external comparison group were excluded. Another four projects were excluded because their research data were not submitted in a format that permitted aggregation with the data from all other projects. Two additional projects were excluded due to changes in the research design that occurred during the projects and resultant concerns as to the nature and appropriateness of the final comparison groups.

TABLE A: CRIMINAL JUSTICE OUTCOMES

#	OUTCOME VARIABLE	ENHANCED TREATMENT (ET)	TREATMENT AS USUAL (TAU)	SAMPLE SIZE ET	SAMPLE SIZE TAU
1	Any booking	53.3%	56.2%	1,288	1,234
2	Mean bookings	0.531	0.498	2,418	2,197
3	Booking offense-felony	29.3%	32.5%	660	663
4	Any conviction	35.3%	38.3%	852	841
5	Mean convictions	0.285	0.304	2,415	2,198
6	Conviction offense-felony	22.1%	25.9%	467	506
7	Any jail time	54.4%	57.1%	1,312	1,249
8	Mean jail days	13.7	15.2	2,410	2,189

Statistically significant positive results
Positive results approaching statistical significance
Results in the negative direction; not statistically significant

Quality of Life Outcomes: The enabling legislation for the MIOCRG program outlined specific strategies counties must incorporate into their projects to help persons with a serious mental illness improve their ability to function productively and independently within the community through such things as a stable source of income and a safe and decent residence. The analysis of data related to these "quality of life" issues shows that the MIOCRG projects had a statistically significant, positive impact on five of the six outcome variables included in the statewide research (Table B).

TABLE B: QUALITY OF LIFE OUTCOMES

#	OUTCOME VARIABLE	ENHANCED TREATMENT (ET)	TREATMENT AS USUAL (TAU)	SAMPLE SIZE ET	SAMPLE SIZE TAU
9	Drug problem	44.8%	55.3%	730	352
10	Alcohol problem	38.2%	49.6%	623	314
11	GAF score improved	64.3%	44.3%	645	321
12	Homeless	7.3%	12.0%	126	91
13	Unemployed	43.1%	39.0%	747	297
14	Economic self-sufficiency	32.0%	24.2%	684	813

Of particular note in these findings is the improvement in scores on the Global Assessment of Functioning (GAF) scale. GAF scores are clinical assessments of overall psychological, social and occupational functioning based on a 100-point scale. Higher scores reflect better overall functioning. The average GAF score at intake of those in the database was 45.6. A GAF score of 40 is indicative of major impairment in areas such as judgment, thinking, mood or social or work relations; a score of 50 is considered indicative of serious psychological symptoms or serious impairment in social or occupational functioning. Over 40% of the individuals in both research groups experienced no change in GAF score (42.3% for ET and 41.8% for TAU). The results in Table B are for the individuals whose scores changed. For the 1,003 individuals in the ET group that experienced a change in GAF score, 64.3% exhibited an improvement in their functioning. In contrast, of the 741 in the TAU group who experienced a change in GAF score, only 25.7% exhibited an improvement in functioning, while the functioning of 55.7% worsened.

Subgroup Analyses: An important finding of previous BOC grant research is that no program works equally well for all categories of program participants. With this in mind, the BOC's research staff conducted a preliminary analysis to determine differences on outcome measures for 10 subgroups of participants. Based on this analysis and time constraints, staff focused on four subgroup factors that appeared to have the strongest interaction with treatment effects (age, criminal intensity, substance/alcohol abuse, and employment) and investigated the relationship between these factors and two outcome measures (Any Booking, and GAF Change).

TABLE C: AGE/CI SCORE AND "ANY BOOKING" OUTCOME

SUBGROUP	ENHANCED TREATMENT (ET)	TREATMENT AS USUAL (TAU)	SAMPLE SIZE ET	SAMPLE SIZE TAU
< 30 years of age	58.7%	57.5%	398	327
30+ years of age	51.8%	57.6%	884	885
Low CII score	42.2%	42.8%	237	216
Medium CII score	53.5%	54.2%	628	565
High CII score	63.3%	71.7%	349	386
< 30, Low CII score	47.1%	39.2%	73	49
< 30, Medium CII score	59.0%	60.5%	197	156
< 30, High CII score	69.4%	66.7%	111	106
30+ Low CII score	40.0%	45.3%	161	163
30+ Medium CII score	52.2%	54.4%	430	398
30+ High CII score	62.5%	75.9%	238	277

Statistically significant positive results
Results in the positive direction, not statistically significant
Results in the negative direction; not statistically significant

As illustrated in Table C, the analysis for Age/Criminal Intensity (CI) score[2] and Any Booking revealed that the results for participants 30 years of age and older were better than the results for younger participants, that the positive treatment effect size increased with the CI score, and that the largest treatment effect occurred with older participants with high CI scores.

This analysis on the Any Booking outcome also found that older participants with no-self report of substance abuse problems at intake had better outcomes than those with substance abuse problems, and that participants who were not seeking employment (i.e., had adequate means of support from family or public assistance) exhibited a bigger treatment effect in the desired direction (6.7% difference between the ET and TAU groups). For older participants, the "ET advantage" increased to 10.4%.

The subgroup analysis results for the GAF Change outcome were as follows:

- The larger treatment effects occurred with older participants with high CI scores; however, the interaction between age and GAF Change was not as dramatic as for the Any Booking outcome measure. In this case, the biggest ET/TAU treatment effect occurred for older participants with medium CI scores.

- Unlike for the Any Booking outcome, the larger treatment effects for GAF change occurred with participants who reported substance abuse problems at intake. There was also an interaction with age. Almost twice the percentage of older TAU participants with substance abuse problems experienced a worsening of their GAF score than did similar ET participants (41.2% versus 22.5% respectively).

- In contrast to the Any Booking results, the biggest treatment effect for GAF Change occurred with the unemployed participants. More than twice the percentage of older unemployed TAU participants experienced a worsening of their GAF score than did similar ET participants (45.4% versus 18.2% respectively).

ACT Fidelity: The third piece of the statewide research examined the relationship between treatment effects and the extent to which projects incorporated the attributes of the Assertive Community Treatment (ACT) model (Attachment 4). These attributes have become the basis for several rating scales of ACT fidelity, thereby making it possible to measure the extent to which mental health care programs are characterized by "ACTness." One such rating scale is the Dartmouth ACT Scale (DACTS).[3] The items in the DACTS comprise three subscales. The Human Resources: Structure & Composition Subscale focuses on a variety of staffing issues, including overall client to staff ratio, the extent to which the provider group functions as a team, continuity of staff, and the client to staff ratio for various disciplines on the team (psychiatry, nursing, etc.). The Organizational Boundaries Subscale addresses issues such as explicitness of admission criteria, extent of responsibility for treatment services, 24/7-access to emergency services, and the provision of time-unlimited services. The Nature of Services Subscale contains items regarding location and frequency of client contact, assertive client engagement, intensity of services, individualized substance abuse treatment and the use of dual-diagnosis treatment models.

---

[2] Criminal history at intake was measured using a Criminal Intensity Index that takes into account the frequency and severity of booking during the three 12-month periods prior to program participation as well as the severity of the qualifying booking leading to entry into the program.

[3] Teague GB, Bond GR, Drake RE. Program fidelity in assertive community treatment: Development and use of a measure. American Journal of Orthopsychiatry 1998; 68: 216-32.

Program staff from each MIOCRG project provided a single rating for each item in the DACTS. Treatment effects associated with degree of "ACTness" were examined by assigning the projects into low, medium and high categories based on total DACTS score. Projects with total DACTS scores of 79 or less were assigned to the low category, those with total DACTS scores between 80 and 100 were assigned to the middle category, and the remaining projects were assigned to the high category.

The results of this analysis suggest that the degree of "ACTness" was associated with desired program effects, both in terms of criminal justice and quality of life outcome measures. For example, with regard to the criminal justice outcomes, eight of the nine statistically significant ET/TAU group differences in the desired direction occurred in medium and/or high ACT programs. In contrast, there were only two statistically significant differences among low ACT programs, on felony booking and mean bookings, and the latter was in the undesired direction (i.e., lower for the TAU group).

A similar pattern of results was obtained for most of the quality of life outcomes. In terms of drug and alcohol use, for example, no statistically significant group differences were found for low ACT programs, whereas significant differences in the desired direction (i.e., a lower percentage of those in the ET group with drug or alcohol problems) were obtained for medium and high ACT programs. The same general pattern of results was also obtained for GAF score changes, with statistically significant results in the desired direction obtained for the medium and high ACT programs only (i.e., a lower percentage of ET cases with reduced GAF scores). In the case of Housing (Homeless Outcome), a significant difference in the desired direction was found for medium ACT programs only. No evidence was found that the degree of "ACTness" was associated with ET/TAU differences in employment or economic self-sufficiency.

Highlights of What Worked

The statewide research found a clear and compelling advantage for the overarching MIOCRG strategy emphasizing accurate diagnosis, timely services, close offender monitoring, and post-custody aftercare interventions. In addition to the findings of this research, the case studies required in counties' final evaluation reports and project staff assessments of the most effective elements of their programs yielded strong commonality that the following 10 strategies worked best in helping mentally ill offenders avoid further involvement in the criminal justice system.

- Interagency Collaboration
- Intensive Case Management
- Involvement of the Courts
- Mental Health Courts
- Assistance Securing Benefits
- Assistance Arranging Housing
- Medication Management
- Use of a Center or Clinic
- Assistance with Transportation
- Peer Support

Attachment 1
MIOCRG GRANTEES

The first allocation to the MIOCRG program (Chapter 502, Statutes of 1998 and the 1999/00 Budget Act) supported 15 grants that began in July 1999. For administrative purposes, these grantees were referred to as MIOCRG I counties. An augmentation to the MIOCRG program (2000/01 Budget Act) supported 15 additional grants that began in July 2001 (MIOCRG II counties).

MIOCRG I COUNTIES	AWARD	MIOCRG II COUNTIES	AWARD
Humboldt	$2,268,986	Alameda	$3,122,064
Kern	$3,098,768	Butte	$1,796,746
Los Angeles	$5,000,000	Kern	$1,224,970
Orange	$5,034,317	Los Angeles	$3,122,064
Placer	$2,139,862	Marin	$2,650,399
Riverside	$3,016,673	Mendocino	$1,241,037
Sacramento	$4,719,320	Monterey	$1,627,858
San Bernardino	$2,477,557	San Bernardino	$2,752,610
San Diego	$5,000,000	San Francisco	$2,178,201
San Francisco	$5,000,000	San Joaquin	$2,607,436
San Mateo	$2,137,584	Santa Clara	$ 747,312
Santa Barbara	$3,548,398	Solano	$3,108,840
Santa Cruz	$1,765,012	Tuolumne	$ 520,266
Sonoma	$3,704,473	Ventura	$1,536,396
Stanislaus	$1,713,490	Yolo	$1,688,750
TOTAL	**$50,624,440**	**TOTAL**	**$29,924,949**

Attachment 2

BACKGROUND CHARACTERISTICS OF CASES IN FINAL DATABASE

Demographics		Enhanced Treatment (ET)[4]	Treatment As Usual (TAU)[5]	Total[6]
Age (Mean)		36.16	36.19	36.17
Male		56.7%	59.5%	58.0%
Marital Status, Intake	Divorced	21.1%	22.1%	21.6%
	Married	10.1%	11.3%	10.6%
	Never Married	55.1%	54.3%	54.8%
	Separated	11.4%	9.6%	10.6%
	Widowed	2.3%	2.6%	2.5%
Employment Status, Intake	Employed	18.8%	19.9%	19.3%
	Not Employed	30.8%	32.3%	31.4%
	Unemployed	50.4%	47.8%	49.3%
Homeless at Intake		20.0%	25.3%	22.2%
Clinical Status		Enhanced Treatment (ET)	Treatment As Usual (TAU)	Total
Primary DSM IV Disorder, Intake	Substance Abuse	1.7%	1.9%	1.8%
	Delusional	27.7%	25.2%	26.5%
	Psychotic	.7%	.4%	.6%
	Schizophrenia	10.0%	11.7%	10.8%
	Bipolar	25.8%	25.4%	25.6%
	Depressive	29.4%	29.8%	29.6%
	Anxiety	2.9%	3.2%	3.0%
	Other	1.7%	2.5%	2.1%
GAF, Intake (Mean)		45.87	45.25	45.58
Alcohol Problems		48.1%	49.2%	48.5%
Drug Problems		59.3%	59.0%	59.1%
Criminal History		Enhanced Treatment (ET)	Treatment As Usual (TAU)	Total
Criminal Intensity Score (Mean)		13.44	13.82	13.62

[4] N = 2,161 to 2,456
[5] N = 1,493 to 2,255
[6] N = 3,654 to 4,711

Attachment 3
STATEWIDE EVALUATION OUTCOME MEASURES

Bookings for ET vs. TAU group members in terms of:

1. **Any Booking**. The percentage that was booked during their two-year, post-incarceration involvement in the program.
2. **Mean Bookings**. The mean number of bookings per six-month program participation period during the two-year, post-incarceration involvement in the program.
3. **Booking Offense**. The seriousness of the offenses that led to the bookings.

Convictions for ET vs. TAU group members in terms of:

4. **Any Conviction**. The percentage that was convicted during their two-year, post-incarceration involvement in the program.
5. **Mean Convictions**. The mean number of convictions per six-month program participation period during the two-year, post-incarceration involvement in the program.
6. **Conviction Offense**. The seriousness of the offenses that led to the convictions.

Jail incarceration for ET vs. TAU group members in terms of:

7. **Any Jail Time**. The percentage that served jail time during their two-year, post-incarceration involvement in the program.
8. **Mean Jail Days**. The mean number of jail days per six-month program participation period during the two-year, post-incarceration involvement in the program.

Substance abuse problems for ET vs. TAU inmates in terms of:

9. **Drug Problem**. The percentage of participants with drug problems at the end of their two-year, post-incarceration involvement in the program.
10. **Alcohol Problem**. The percentage that reported alcohol problems at the end of their two-year, post-incarceration involvement in program.

Mental health status for ET vs. TAU inmates in terms of:

11. **GAF Change**. The percentage of participants who experienced an improvement, no change or a worsening of their Global Assessment of Functioning (GAF) score between intake and their final program assessment.

Quality of life status for ET vs. TAU inmates in terms of:

12. **Housing Status**. The percentage of homeless at the end of their two-year, post-incarceration involvement in the program.
13. **Employment Status**. The percentage that lacked employment (of those not supported in some other manner) at the end of their two-year, post-incarceration involvement in the program.
14. **Economic Self-Sufficiency**. The percentage of six-month periods after incarceration for the two-year post-incarceration involvement in the program that research subjects experienced "economic sufficiency" (i.e., were self sufficient in that they received enough funds to cover living expenses either from a job or from their family or public assistance, versus those that needed a job to support themselves and were unable to secure one).

Attachment 4
ACT CRITERIA

Multidisciplinary staffing. ACT enriched programs consist of a group of mental health care professionals, with each individual providing expertise in a specific area of care necessary for the person with Severe Mental Illness (SMI). A typical ACT staff might consist of psychiatrists, nurses, social workers, rehabilitation counselors, and substance abuse counselors.

Integration of services. ACT promotes an integrated approach to health care delivery, wherein each member of the multidisciplinary team of providers is aware of the efforts of the other team members, and the impact of those efforts on the client

Team approach. A full integration of services implies a team approach to treatment. ACT team members share caseloads and meet frequently to discuss clients, solve client-related problems, and jointly plan treatment and rehabilitation.

Low client-staff ratios. ACT programs seek to ensure one-on-one contact between the client and provider and to provide individualized services. This is optimized when there is a low ratio of clients to staff. The rule of thumb for ACT programs is about 10:1. This contrasts with non-ACT case management programs where the ratio may be as high as 50:1.

Locus of contact in the community. Most contacts with clients and others involved in their treatment occur where the clients live, work and interact with others (*in vivo* contacts), rather than in the offices and places of work of the providers (hospital, clinic, etc.).

Medication management. ACT regards the effective use of medication and medication management as of paramount importance.

Focus on everyday problems in living. In addition to placing great emphasis on medication management, ACT personnel also focus on the range of activities and chores that the client confronts daily. Examples include securing housing, making and keeping appointments, cashing checks, shopping, and dealing with landlords.

24-hour access. ACT services are frequently available 24 hours a day, 7 days per week. ACT teams also respond quickly to emergencies, so that minimal time elapses between the onset of the crisis and the appearance of care.

Assertive outreach. ACT takes an aggressive approach to engaging and maintaining relationships with clients in outreach efforts that emphasize relationship building and the provision of tangible social services. Clients who miss appointments are not automatically terminated from ACT programs.

Individualized services. Treatment and services are tailored to the individual needs and preferences of the client, and due to the breadth of community resources available, the team is able to maximize client options.

Time-unlimited services. Clients do not separate from ACT programs once their situation has stabilized, but rather continue to receive ACT assistance on an ongoing basis as needed.

Other common characteristics of ACT programs are the active support, preparation and involvement of the family in the client's treatment plan, and the provision of vocational assistance to help clients find and maintain employment.